

FIG. 1

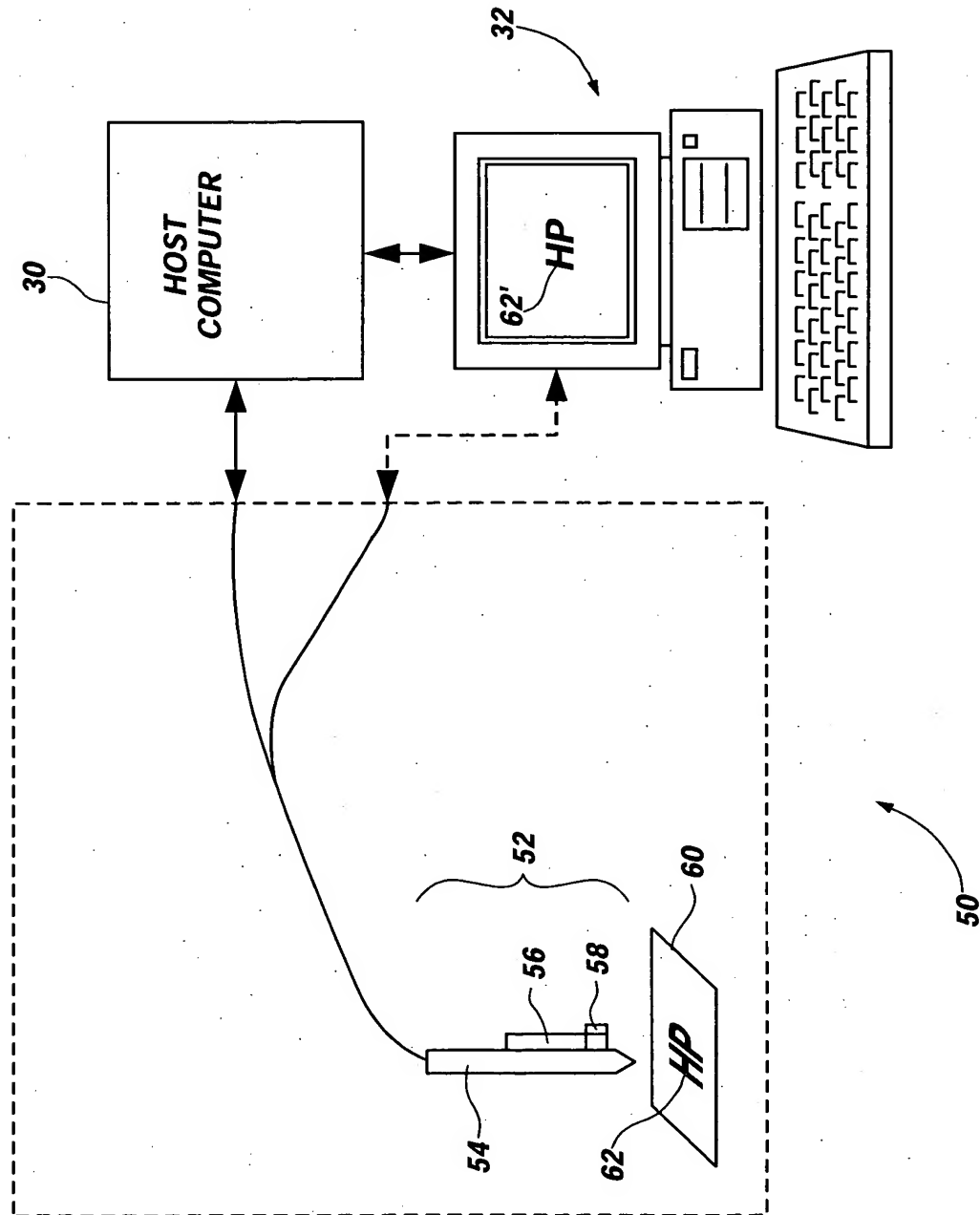


FIG. 2

printed using HP laserjet technology

Location Address

FIG. 3B

TE
t/Accessories.

FIG. 3C

Section B Applicant's Medical History											
<p>- Section B is to be completed in the presence of the Medical Examiner and by all applicants unless otherwise stated. - Where not applicable please place N/A next to the question. - If space is not enough please attach an additional sheet of paper and have this signed by the Medical Examiner.</p>											
B-1	<p>Have you visited a doctor in the last three years? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Have you ever received hospital treatment or been hospitalized for any reason? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Have you ever undergone or been advised to have surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Are you taking any pills, medicines or having other treatments? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you have any physical/mental/emotional/developmental/intellectual disabilities which may affect your ability to earn a living or take full care of yourself? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you receive a sickness benefit, a pension or any other welfare benefit for medical reasons? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, please provide details:</p> <table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>										
B-2	<p>Personal habits of applicant (if over 12 years old):</p> <p>Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Have you ever smoked? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you have any history of dependence on alcohol or other substances (e.g. opiates, cocaine, barbiturates, tranquilizers, sedatives, hypnotics)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, please provide details as follows:</p> <table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>										
B-3	<p>Are you suffering from, or have you ever suffered from any of the following:</p> <p>a) Tuberculosis (or have you had contact with a person who has had tuberculosis)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>b) Leprosy? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>c) Venereal disease (sexually transmitted disease) - specify? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, please provide details as follows:</p> <table border="1"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>										

FIG. 4

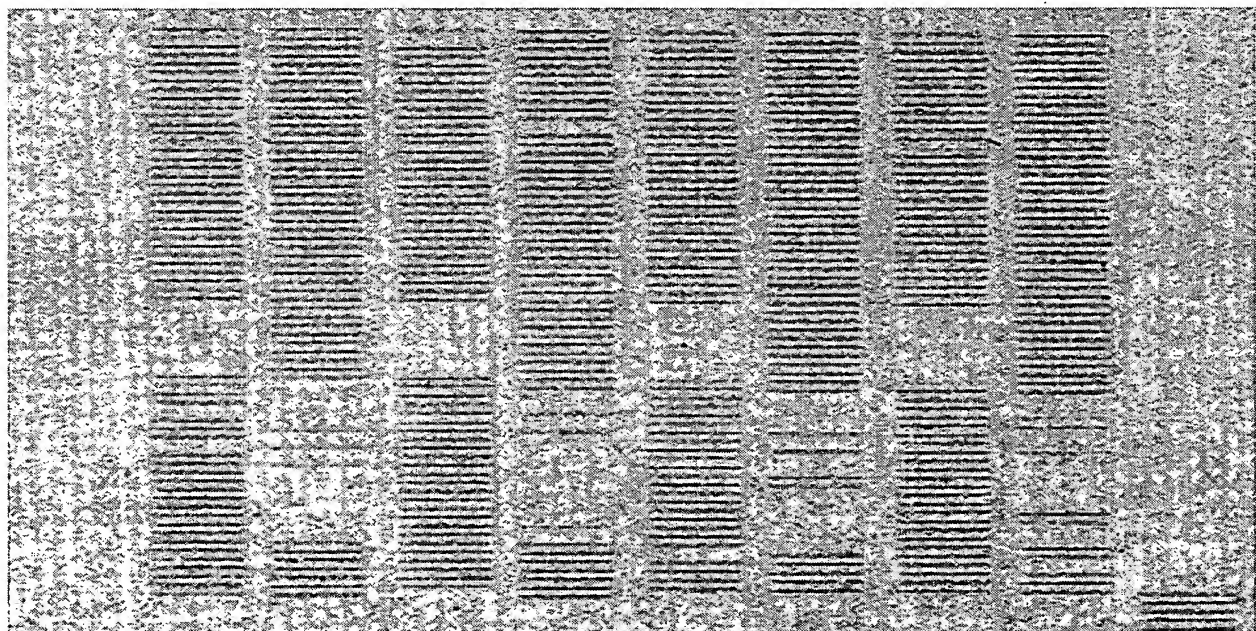


FIG. 5

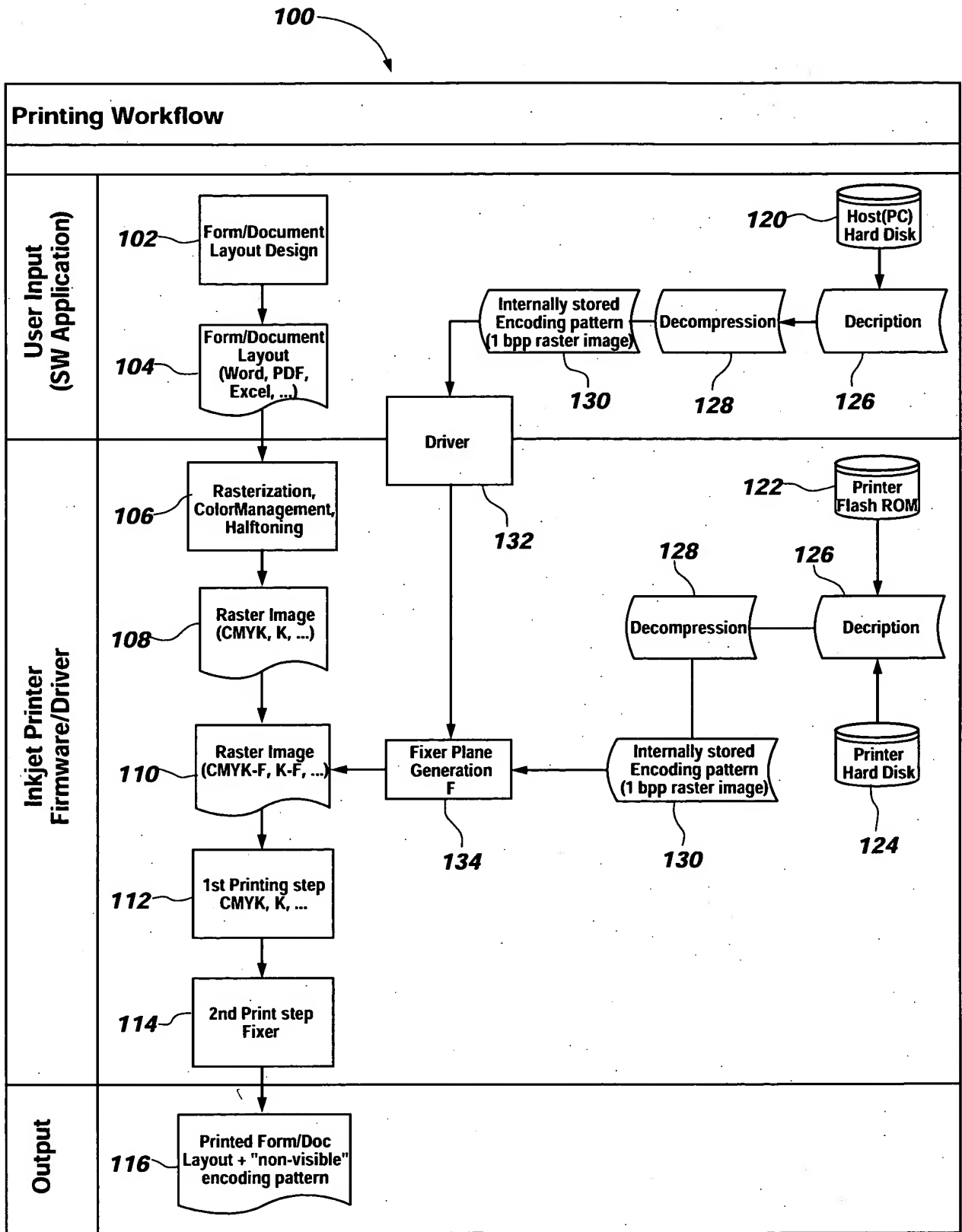


FIG. 6